At present it would seem prudent to advise patients to be wary of online therapy. Can the College do anything to prevent its name being associated with websites of questionable therapeutic value?

Reference

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ANDREW GRAY, *Specialist Registrar in Psychiatry, Gartnavel Royal Hospital, 1055 Great Western Road, Glasgow G12 0XH*

The College is aware of the Cyberanalysis clinic website and has been in contact with Dr Razzaque and his psychiatric tutor. We have agreed that the reference within the website to Dr Razzaque as being an Inceptor within the Royal College of Psychiatrists should be removed.

CORNELIUS KATONA, *Dean, Royal College of Psychiatrists, 17 Belgrave Square, London SW1X 8PG*

Sir: Thompson's article on the internet and suicide (*Psychiatric Bulletin*, August 1999, **23**, 449–451) is a timely and welcome addition to the slowly growing literature on the internet and health. However, she could possibly have developed further positive ways of approaching the influence of the internet. Attempting to shut down, or restrict access to internet sites dealing with suicide is likely to be difficult to enforce in practice and may inadvertently block access to sources of positive help. It is important to stress the potential benefits of support online. The vast majority of online informants of my current thesis in medical anthropology on chronic fatigue syndrome and internet use reported that it provided a lifeline in the face of prejudice and lack of sympathy for family and desertion by friends. There is a vast untapped potential for NHS trusts and bodies such as Mind, or the Royal College of Psychiatrists to set up websites, moderated newsgroups and Internet Relay Chat (IRC) services to provide more therapeutic approaches to suicide and mental illness than those described by Thompson.

Training, campaigns such as the Defeat Depression campaign and clinical service provision (especially in such an arena as child and adolescent psychiatry) could be adjusted much more to take into account the emerging phenomena of the Internet.

ANNIE MCCLOUD, *MSc Student in Medical Anthropology, Department of Anthropology, University College, Gower Street, London WC1E 6BT*

The alternative journal club

Sir: We read with interest the paper by Coombe *et al* subtitled 'The alternative journal club' (*Psychiatric Bulletin*, August 1999, **23**, 497–500). It raises an interesting approach to enlivening a local programme of educational meetings, and one with which we have also had some success. However, we were struck by the need to re-engineer the 'conventional' element of the journal club in order to meet the criteria defined by the Royal College of Psychiatrists' guidelines (Royal College of Psychiatrists, 1996). In our case this was not prompted by poor attendance, but rather frustration that the traditional format of a trainee finding a paper and presenting it did not produce the desired outcome of a change in knowledge and thus an improvement in clinical care. What is more, it also failed to fulfil the new goal of preparing trainees for the critical review paper of the MRCPsych Part II Examination.

We decided to adopt the approach promoted by Sackett and others (Sackett *et al*, 1997) making an educational prescription the central component of the journal club. At each meeting those attending would generate a relevant clinical question, usually relating to a problem encountered in day to day practice. One recent example involved the case of a patient with recurrent bipolar affective disorder, which brought forward a clinical question regarding the use of new generation antipsychotics in both acute treatment and prophylaxis. The following week a trainee presented the search strategy used to obtain the best available evidence, making extensive use of the Centre for Evidence-Based Mental Health (CEBMH) website (www.psychiatry.ox.ac.uk/cebmh). The latter seems to be the most accessible way of reaching a variety of high quality evidence, and trainees were able to perform detailed searches with minimal extra training. A copy of the paper containing the best evidence was circulated to the other members of the journal club, and it was subjected to critical analysis using techniques examined in the MRCPsych Part II Exam. The ensuing discussion usually resulted in a decision as to whether or not the findings should then be adopted into routine practice locally.

This method collapses the three-stage process suggested by Sackett (Sackett *et al*, 1997) into a

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two-stage procedure. We found that this was more manageable, particularly as sustaining interest in the topic over three weeks was difficult. It also allowed us to include both audit and some 'non-conventional' presentations in the programme. It meant more work for one individual (as Sackett's method involves a group discussion resulting in the best evidence to appraise), but as trainees became more familiar with using resources such as the CEBMH the time involved was reduced.

Thus, we have found that this methodology is both stimulating and useful, and believe that it has the potential to deliver better care for our patients. The major difficulties have been overcoming the inertia of changing the old methods by teaching new skills, and often the dearth of quality information to answer our questions! However, we are confident that both will change given time, and from our own experience this change will be for the better.

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Psychopathic disorder and autistic spectrum disorders

Sir: We write with respect to Council Report CR71 on *Offenders with Personality Disorders* published earlier this year (Royal College of Psychiatrists, 1999) just prior to the release of the Home Office Document *Managing Dangerous People with Severe Personality Disorder; Proposals for Policy Development* (Home Office, 1999). Both documents deal to some degree with the issue of the legal term 'psychopathic disorder' and its relationship to severe personality disorder. In addition the Home Office document introduces a new term 'dangerous severe personality disorder' (DSPD) and seeks to highlight the complexity of this area.

However, there is an important issue that has been overlooked by both documents and has fundamental implications for any future service provision. This is the significant number of individuals detained under the legal category of psychopathic disorder who have autistic spectrum disorders. Some of these individuals have been classified as having personality disorders, usually schizoid, schizotypal or anankastic in type. A number are already in a variety of different secure provisions, some in forensic psychiatric services including special hospitals. This issue was recognised by Coid (1992) in his important survey of individuals held under the category of psychopathic disorder but appears to have been overlooked in these two recent influential documents.

It is likely that the service provision for these individuals will need to be quite different from provision for antisocial or dissocial personality disorders. Autistic spectrum disorders are much more common than previously believed, but there has been little research in the areas of outcome or their long-term management, particularly in forensic settings.

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Guidelines on the management of imminent violence

Sir: The Royal College of Psychiatrists' *Guidelines for the Management of Imminent Violence* (1998) offer an evidence-based approach to dealing with the problem of violence in psychiatric settings. The guidelines imply that a prototypical violent episode is perpetrated by a patient with psychosis and is therefore manageable using a combination of psychological intervention, containment, restraint and medication.

In Bradford Community NHS Trust there were 1254 reported violent incidents for the year 1996–1997 (further details available from the